

The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street
Boston, MA 02108
(617) 973-0971

www.mass.gov/dph/dentalboard

Facility Permit D-H

(See 234 CMR 6.08 Effective August 20, 2010)

Facility Requirements for Dental Offices Using Mobile and/or Portable Anesthesia Services

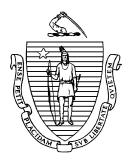
Application Instructions

Each dental facility or practice site utilizing mobile or portable anesthesia services is required to have a Facility Permit D-H. The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper individual anesthesia permit and a current facility permit D-P (see.6.09) issued by the Board, and that the portable anesthesia service is appropriately permitted and equipped in accordance with 234 CMR 6.00 for the level of pain control and/or sedation to be provided.

The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper anesthesia permit and that the portable anesthesia service is appropriately permitted for the level of pain control and/or sedation to be provided.

If you already hold a current Facility Permit D for the level of anesthesia you plan to have administered by a Portable Dental Operation, please do not submit this application.

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Application – Facility Permit D-H

1. APPLICANT NAME				MA DN Lic. #		
	Last	First	MI			
2. FACILITY ADDRESS:						
	No.	Street		Unit #		
_	City/Town		State	Zip Code		
3. Business Name/Do	ING BUSINESS	As:				
4. TELEPHONE NUMBE	r-Day:	C1	ELL:	FAX:		
5. EMAIL ADDRESS:						
6. PRACTICE OWN	ER (if differen	t from applicant)				
Name:				_MA Dental Lic. #		
Telephone:			Email:			
7. FACILITY DENTA	AL DIRECTO	PR (if applicable – see 2	234 CMR 5.02 (3))		
Name:				_MA Dental Lic. #		
Telephone:			Email:			
8. TYPES OF ANEST	THESIA					
TYPE(S) OF ANEST TO BE ADMINISTE (Check all that apply.	RED	OR SEDATION				
Nitrous Oxide-Oxyge Nitrous Oxide-Oxyge Oral Sedation Only I.V. Sedation General Anesthesia at Other route of admin	n + Oral Seda nd Deep Seda	tive(s)				

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	FACILITY PERMIT D-H APPLICATION ATTACHMENTS	
	Attachment 1: Personal or business check or money order made payable to THE COMMO	
	OF MASSACHUSETTS in the amount of \$180. All fees are nonrefundable and nontrar	
	Attachment 2: Required Equipment and Emergency Drugs, as applicable (see form attach	
	Attachment 3: Copy of a schedule and log demonstrating the regular inspection of all emer	
	and equipment for administration of anesthesia at the office site, including the date(s) and n	ame of person
	who last checked drugs and equipment and the results of the checks, including that of the co	ondition of
	equipment according to manufacturers' specifications.	
APPLI	ICANT ATTESTATION: 1	Y CERTIFY,
ALLDI	Print Full Name of Applicant	i cerii i,
UNDER	R THE PAINS AND PENALTIES OF PERJURY, THAT:	
•	ALL INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE;	
	I HAVE READ AND UNDERSTOOD THE STANDARDS AND REQUIREMENTS FOR FACILITY PR	ERMITS AS
	PROMULGATED BY THE BOARD ON AUGUST 20, 2010 AT 234.CMR 6.03 AND 6.08	
•	I READ AND UNDERSTOOD THE REQUIREMENTS FOR ADMINSTRATION OF GENERAL ANE	STHESIA,
	DEEP SEDATION, MODERATE SEDATION, MINIMAL SEDATION AND NITROUS OXIDE-OXYG	
	CMR 6.11-6:14 AND THAT THE QUALIFIED DENTAL ANESTHESIOLOGIST HAS THE PROPER	ANESTHESIA
	PERMIT AND THAT THE PORTABLE ANESTHESIA SERVICE IS APPROPRIATELY PERMITTE LEVEL OF PAIN CONTROL AND/OR SEDATION TO BE PROVIDED FOR THE OFFICE.	D FOR THE
	LEVEL OF PAIN CONTROL AND/OR SEDATION TO BE PROVIDED FOR THE OFFICE.	
•	I AM CURRENTLY, AND WILL CONTINUE TO BE, IN COMPLIANCE WITH ALL STATUTES, RUREGULATIONS PERTAINING TO THE PRACTICE OF DENTISTRY IN THE COMMONWEALTH	JLES, AND
	MASSACHUSETTS AS REQUIRED BY LAW.	Or
	MADDACHODE I TO AD REQUIRED DI LAW.	

SIGNATURE OF APPLICANT: ______DATE: _____

APPLICATION IS VALID ONLY 90 DAYS UPON RECEIPT.

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Attachment 2

AT A MINIMUM, A FACILITY THAT HOSTS A MOBILE OR PORTABLE DENTAL ANESTHESIA SERVICE WILL BE REQURED TO HAVE THE FOLLOWING EQUIPMENT AND DRUGS

EQUIPMENT REQUIRED	DATE LAST INSPECTED
Alternative light source for use during power failure	
Ambu-bag or portable bag-mask ventilator	
Automated or manual external defibrillator, including batteries and other components	
Disposable CPR mask (pediatric and adult)	
Disposable syringes (assorted sizes)	
Latex free tourniquet	
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive	
pressure ventilation including bag-valve-mask system	
Sphygmomanometer and stethoscope (pediatric and adult)	
Suction	

EMERGENCY DRUGS AND DRUG CLASSIFICATIONS REQUIRED BY 234 CMR 6.08 TO BE PROVIDED AND MAINTAINED AT SITE

REQUIRED DRUGS	NAME OF DRUG	DOSAGE	EXPIRATION DATE
Acetylsalicylic acid (rapidly absorbable			
form)			
Ammonia inhalants			
Antihistamine			
Bronchodilator			
Epinephrine pre-loaded syringes (pediatric			
and adult)			
2 Epinephrine ampules			
Oxygen			
Vasodilator			
Vasopressor			

NAME(S) OF DENTIST(S)/ANESTHESIOLOGIST(S) WHO WILL BE ADMINISTERING ANESTHESIA AT THIS FACILITY	LICENSE NUMBER	ANESTHESIA PERMIT NUMBER	ACLS/BLS CERTIFICATION EXPIRATION DATE
Dental Director:			

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Attachment 2 (page 2)

NAME(S) OF DENTAL/SURGICAL ASSISTANT(S)	LICENSE NUMBER	CPR/BLS CERTIFICATION EXPIRATION DATE

SIGN AND SEND THIS APPLICATION AND ALL REQUIRED ATTACHMENTS TO:

BUREAU OF HEALTH PROFESSIONS LICENSURE

BOARD OF REGISTRATION IN DENTISTRY

250 WASHINGTON ST., BOSTON, MA 02108

KEEP A COPY OF THIS APPLICATION AND ALL ATTACHMENTS FOR YOUR RECORDS

INCOMPLETE APPLICATIONS WILL BE RETURNED.

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